

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY CAROLINE				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE							
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON				c. LENGTH OF STAY IN lb life							
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)				d. STREET ADDRESS DENTON 05-1							
3. NAME OF DECEASED (Type or print) ANNA				First AMELIA	Middle COHEE	Last COHEE	4. DATE OF DEATH Month JAN	Day 14	Year 1966	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Aug. 25-1885	9. AGE (in years at birth) 80 yrs	10. IF UNDER 1 YEAR Months 0	11. IF UNDER 24 HRS. Days 0	12. Hours 0	13. Minutes 0		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at HOME				10b. KIND OF BUSINESS OR INDUSTRY —				11. BIRTHPLACE (County & State, or foreign country) MARYLAND			
13. FATHER'S NAME GEORGE GRAVATT				14. MOTHER'S MAIDEN NAME GEORGIA MURPHY				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) NO			
16. SOCIAL SECURITY NO.				17. INFORMANT REBECCA WALDECK, DENTON, MD.				Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)				INTERVAL BETWEEN ONSET AND DEATH							
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4222				Cardiac Failure							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) Mycarditis				6 mos.							
DUE TO } (c) Valvitis				1 mo							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) DENTON	(County) MARYLAND	(State) M.D.				
21. I certify that (I) (this hospital) attended the deceased from S-21 , 19 65 to Jan. 14 , 19 66 that (I) (we) last saw the deceased alive on Jan. 14 , 19 66 , and that death occurred 6:40 P.M. from the causes and on the date stated above.											
22e. SIGNATURE Lawson George				M.D. <input type="checkbox"/>	ATTENDING PHYS. <input type="checkbox"/>	MED. DIRECTOR <input type="checkbox"/>	STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED 1-17-66			
22c. PHYSICIAN'S NAME (Type) Lawson George M.D.				22d. ADDRESS Denton, Md. 21629							
23a. BURIAL, CREMATION REMOVAL (Specify) Burial Jan. 17, 1966		23b. DATE THEREOF JAN 17, 1966	23c. NAME OF CEMETERY OR CREMATORIAL DENTON	23d. LOCATION (City, town or county) DENTON							
24. FUNERAL DIRECTOR'S SIGNATURE J. Wright Moore Denton, Md.				ADDRESS 11 N. High Street Denton, Md.				25a. REC'D. BY REGISTRAR DATE JAN 21 1966		25b. REGISTRAR'S SIGNATURE Charles Judge	

ciclo

1900

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any copy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 4. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

00525

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 00516

1. PLACE OF DEATH

a. COUNTY

CAROLINE

MARYLAND

b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)

DENTON

c. LENGTH OF STAY IN TB

d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)

3. NAME OF
DECEASED
(Type or print)

First

Middle

Last

4. DATE
OF
DEATH

Month

Day

Year

5. SEX

M

6. COLOR OR RACE

C

7. MARRIED NEVER MARRIED WIDOWED DIVORCED

8. B. DATE OF BIRTH

SEPT 4, 1908

9. AGE (In years
last birthday)
yrs.

37

10. IF UNDER 1 YEAR
Months Days Hours Min.e. IS RESIDENCE
ON A FARM?
YES NO 10a. USUAL OCCUPATION (Give kind of work
done during most of working life, even if retired)

SANITOR

10b. KIND OF BUSINESS OR INDUSTRY

CUSTODIAL

10c. BIRTHPLACE (State or foreign country)

MARYLAND

12. CITIZEN OF WHAT COUNTRY?

USA

13. FATHER'S NAME

CHARLES

14. MOTHER'S MAIDEN NAME

GREENAGE

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

ROBT. GREENAGE DENTON, MD.

Address

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a)

Acute Coronary Occlusion

4201

DUE TO

Conditions, if any, which
gave rise to immediate cause
(a), stating the underlying
cause last.

(b)

DUE TO

(c)

Coronary Sclerosis

Arteriosclerosis

INTERVAL BETWEEN
ONSET AND DEATH
minutes

10 yrs

15yr

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS
PRIMARY OR CONTRIBUTING
CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)

20c. TIME OF INJURY
Month, Day, Year
Hour a.m.
p.m. 1920d. INJURY OCCURRED
While
at work Not While
at work 20e. PLACE OF INJURY (Home, farm,
factory, street, office bldg., etc.)

20f. (City or town)

(County)

(State)

21. I certify that I took charge of the remains described above, held an Autopsy Inspection Inquiry and in my opinion
death resulted from: Natural causes Accident Suicide Homicide Undetermined manner ACTUAL
SIGNATURE

Harold B. Plummer M.D.

CHIEF MEDICAL EXAMINER ASSISTANT MEDICAL EXAMINER DEPUTY MEDICAL EXAMINER

DATE SIGNED

1/28/66

Address (Street, city, town, or county)

22a. BURIAL, CREMATION,
REMOVAL (Specify)

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORIUM

22d. LOCATION (City, town, or country)

(State)

23. FUNERAL DIRECTOR

ADDRESS

24a. REC'D BY REGISTRAR

24b. REGISTRAR'S SIGNATURE

Vivian Moore Denton, MD.

FEB 2 1966

Charles Judge

21200

22200

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00526

CERTIFICATE OF DEATH

02070

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, Pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE	
CAROLINE		MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		b. COUNTY	
RURAL DENTON		CAROLINE	
c. LENGTH OF STAY IN lb		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
life		RURAL DENTON 05-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		d. STREET ADDRESS	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First	Middle
SARAH		SARA	HINES
4. DATE OF DEATH		Month	Day
Jan 26		1966	
5. SEX		6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>
F		N	FEB. 3, 1877
8. DATE OF BIRTH		9. AGE (In years last birthday) yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.
10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at Home		88	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
MARYLAND		USA	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
BENJAMIN GROSS		HARRIET T	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. 17. INFORMANT	
No		Mrs. Fletcher Rayne, Greensboro Md	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		Address	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)		INTERVAL BETWEEN ONSET AND DEATH	
443X		5 days	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		Acute Left Ventricular Failure	
DUE TO (b)		Hypertensive arteriosclerotic heart disease	
DUE TO (c)		Hypertension - arteriosclerosis 4 years	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.		20d. INJURY OCCURRED While Not While at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from March 19 to Jan 25, 1966, that (I) (we) last saw the deceased alive on Jan 25, 1966, and that death occurred at 7 A.M. from the causes and on the date stated above.		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type)		M.D. ATTENDING PHYS. MED. DIRECTOR STAFF PHYS. 22b. DATE SIGNED	
CHARLES H. WINDSCOTT		RIDGELEY, MD 2/3/66-	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		Jan 30, 1966	
23c. NAME OF CEMETERY OR CREMATORIAL		23d. LOCATION (City, town or county) (State)	
BELL'S CHAPEL		RURAL DENTON MD	
24. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
John Smith before Denton			
25a. REC'D BY REGISTRAR DATE		25b. REGISTRAR'S SIGNATURE	
FEB 8 1956		Charles Judge	

07050

05000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH													
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
00527 CERTIFICATE OF DEATH 00517													
Item #2 c & d Film #G377 1/17/66 DO													
1. PLACE OF DEATH a. COUNTY CAROLINE MARYLAND													
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) DENTON 50													
c. LENGTH OF STAY IN lb													
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)													
2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE MARYLAND b. COUNTY CAROLINE													
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Denton 05-1													
d. STREET ADDRESS 410 South Second St.													
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
3. NAME OF DECEASED (Type or print)		First CLARA	Middle	Last HITCHCOCK	4. DATE OF DEATH JAN. 4 1966	Month	Day	Year					
5. SEX F		6. COLOR OR RACE W	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH AUG 23, 1874 91	9. AGE (In years last birthday) yrs.	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS. Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) at home				10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (County & State, or foreign country) MARYLAND	12. CITIZEN OF WHAT COUNTRY? USA							
13. FATHER'S NAME JOSIAH M. HITCHCOCK				14. MOTHER'S MAIDEN NAME MARY UNKNOWN	Address Mrs. Ethel Collier Denton, Md								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? No				16. SOCIAL SECURITY NO.	17. INFORMANT	INTERVAL BETWEEN ONSET AND DEATH 1 Hour							
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) 4222				Chronic Failure						54+5			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, } (b) DUE TO Chronic Myocarditis													
} (c) DUE TO													
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)													
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)	(State)		
21. I certify that (I) (this hospital) attended the deceased from..... 1966 to Jan. 4, 1966 that (I) (we) last saw the deceased alive on Jan. 4, 1966, and that death occurred at 5:45 AM, from the causes and on the date stated above.				22b. DATE SIGNED 1-5-1966									
22a. SIGNATURE Dawson, George M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>					
22c. PHYSICIAN'S NAME (Type) Dawson, George				22d. ADDRESS Denton, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify) DENTON, MD, 1966				23b. DATE THEREOF DENTON		23c. NAME OF CEMETERY OR CREMATORIAL DENTON		23d. LOCATION (City, town or county) DENTON, MD		(State)			
24 FUNERAL DIRECTOR'S SIGNATURE J. VIRGIL MOORE				ADDRESS DENTON		25a. REC'D BY REGISTRAR JAN 11 1966		25b. REGISTRAR'S SIGNATURE Charles Judge		DATE			
VR AIS (4) 20M 5-63													

1100

1200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please affix carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												00518												
CERTIFICATE OF DEATH																								
1. PLACE OF DEATH a. COUNTY			Caroline MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)																		
b. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town)			Rural Greensboro			c. LENGTH OF STAY IN 1D 30 Yrs.						a. STATE Maryland b. COUNTY Caroline												
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) None												e. CITY DR TDWN (If outside corporate limits, write RURAL and give nearest town) Rural Greensboro		f. STREET ADDRESS None		g. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH		Month	Day	Year														
Carlton					Paswater	1	7			1966														
5. SEX		6. COLOR OR RACE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday) 58 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.														
Male		White		WIDWEO <input type="checkbox"/> DIVDRCD <input checked="" type="checkbox"/>		Nov. 21, 1907																		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS DR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country) Maryland			12. CITIZEN OF WHAT COUNTRY? USA															
Retired Boat Painter			None																					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME			Address																		
William E. Paswater			Lula Mae Wilcox			Earl Paswater Greensboro, Maryland																		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes			16. SOCIAL SECURITY NO. 160-24-1558			17. INFORMANT			18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]			INTERVAL BETWEEN ONSET AND DEATH												
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)			Coronary Thrombosis						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>												
4201 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			Arteriosclerotic Cardiovascular Dis.						Renal Insufficiency															
DUE TO (b)						DUE TO (c)																		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Feb. 10 1965 to Jan. 7 1966, that (I) (we) last saw the deceased alive on Jan. 6 1966, and that death occurred at 9:50A M, from the causes and on the date stated above.												22a. SIGNATURE <i>Charles H. Stonesifer</i>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22b. DATE SIGNED 1-8-66							
												22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.			22d. ADDRESS Greensboro, Md. 21639									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Jan. 10, 66			23c. NAME OF CEMETERY OR CREMATORIAL Greensboro			23d. LOCATION (City, town or county) Greensboro, Maryland			(State)												
24. FUNERAL DIRECTOR <i>J E Boules</i>			ADDRESS Greensboro, Md.			25a. REC'D BY REGISTRAR JAN 14 1966			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>															

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do you prefer moderate than not? L do not

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

00523

00519

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal and any event within 72 hours after death.

DEATH: Page 4 may be retained by the hospital or attending physician.

FUNERAL DIRECTOR: After this form has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and any event within 72 hours after death.

VR A15 (4)
15M 7/61

1. PLACE OF DEATH a. COUNTY		2. USUAL RESIDENCE (Where deceased lived, if Institution: Residence before admission)	
CAROLINE		a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	c. LENGTH OF STAY IN IB	b. COUNTY TALBOT	
HURLOCK	3 MONTHS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			
BELLE HAVEN NURSING HOME			
3. NAME OF DECEASED (Type or print)	First M.	Middle Ruth	Last PLUMMER
4. DATE OF DEATH	Month JAN	Day 3	Year 1966
5. SEX	6. COLOR OR RACE	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	MAY 9 1877
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
HOUSEWIFE		11. BIRTHPLACE (County & State, or foreign country)	
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
THOMAS McQUAY		SARAH JANE STARRIT	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> If yes give rank or grade of service		16. SOCIAL SECURITY NO.	
		17. INFORMANT	
		D15-16-8556 Mrs Jerome Chezumur, Easton MD	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]		INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Gangrenous Heart Disease c Failure		4 yrs	
4500 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)		15 yrs	
} DUE TO Generalized Arteriosclerosis (c)		25 yrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)			
Chronic Pyelonephritis			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Hour a.m. p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
19		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)	
(State)			
21. I certify that (I) (this hospital) attended the deceased from 9/20/65, 1965, to 1/3, 1966, that (I) (we) last saw the deceased alive on 12/31/65, and that death occurred at 6:45 A.M. from the causes and on the date stated above.			
22a. SIGNATURE		22b. DATE SIGNED	
<i>J. Plummer</i>		1/4/65	
22c. PHYSICIAN'S NAME (Type)		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
Harold B. Plummer M.D.		22d. ADDRESS	
		Preston Maryland	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF	
Burial		1-6-1966	
23c. NAME OF CEMETERY OR CREMATORIUM		23d. LOCATION (City, town or county)	
OLYMPIA CEMETERY		St. Michaels	
(State)			
24. FUNERAL DIRECTOR'S SIGNATURE			
ADDRESS			
25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Pan 10 1966		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remember carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												00530	00520	
CERTIFICATE OF DEATH														
1. PLACE OF DEATH			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)											
a. COUNTY			b. STATE											
Caroline			Maryland											
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN lb											
Greensboro			2 Yrs.											
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)			e. IS RESIDENCE ON A FARM?											
None			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print)			First	Middle	Last	4. DATE OF DEATH	Month	Day	Year					
Charles			L.		Prescott	1	30				1966			
5. SEX			6. COLOR OR RACE		7. MARRIED	NEVER MARRIED	8. DATE OF BIRTH	9. AGE (In years last birthday)		10. IF UNDER 1 YEAR	11. IF UNDER 24 HRS.			
Male			White		WIDOWED	<input checked="" type="checkbox"/>	8-16-1870	Months	Days	Hours	Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)			12. CITIZEN OF WHAT COUNTRY?					
Retired Farmer			None			Maine			USA					
13. FATHER'S NAME			14. MOTHER'S MAIDEN NAME											
Louis Prescott			Eunice Marrow											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown)			16. SOCIAL SECURITY NO.			17. INFORMANT			Address					
No			Unknown			George Prescott			Greensboro, Md.					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]												INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4221														
Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO Arteriosclerotic Cardiovascular Dis.														
(c) DUE TO Prostatic Hypertrophy and Renal Insufficiency														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) Prostatic Hypertrophy and Renal Insufficiency												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>		
20a. MEDICAL CERTIFICATION			20b. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)									20d. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m.			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)					
19														
21. I certify that (I) (this hospital) attended the deceased from May 1, 1965, to Jan. 30, 1966, that (I) (we) last saw the deceased alive on Jan. 30, 1966, and that death occurred at 9A.M., from the causes and on the date stated above.												22b. DATE SIGNED Feb. 1 '66		
22a. SIGNATURE Charles H. Stonesifer, M.D.												22b. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		
22c. PHYSICIAN'S NAME (Type) Charles H. Stonesifer, M.D.												22d. ADDRESS Greensboro, Md. 21639		
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF 2-4-66			23c. NAME OF CEMETERY OR CREMATORIAL Riverside			23d. LOCATION (City, town or county) (State) Farmington, Maine					
24. FUNERAL DIRECTOR J. E. Boulaire			ADDRESS Greensboro, Md.			25a. REC'D BY REGISTRAR FEB 3 1966			25b. REGISTRAR'S SIGNATURE Charles Judge					
VR A15 (4) 2DM 1/65														

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND												CERTIFICATE OF DEATH			
00531						00521									
1. PLACE OF DEATH a. COUNTY Caroline MARYLAND				2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE Maryland b. COUNTY Caroline											
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Pages 1 and 2 Denton - Rural				c. LENGTH OF STAY IN 1b Life				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Denton - Rural 05-1							
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Pinetown								d. STREET ADDRESS Pinetown				e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> ND <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First James	Middle Franklin	Last Stanford	4. DATE OF DEATH January 17 1966	Month January	Day 17	Year 1966							
5. SEX Male		6. COLOR OR RACE Negro	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDDWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Jan. 21, 1911	9. AGE (In years last birthday) 54 yrs.	10. IF UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer			10b. KIND OF BUSINESS OR INDUSTRY Farming			11. BIRTHPLACE (County & State, or foreign country) Caroline Co., Maryland			12. CITIZEN OF WHAT COUNTRY? USA						
13. FATHER'S NAME Harvey Stanford				14. MOTHER'S MAIDEN NAME Elizabeth Haynes											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. No 219-05-5159		17. INFORMANT Mary E. Stanford, Denton, Maryland, RFD		Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO 4201 Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary atherosclerosis</u> DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH FEW HOURS			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. — 19				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)			
21. I certify that (I) (this hospital) attended the deceased from JAN. 4, 1966, to JAN. 17, 1966, that (II) (we) last saw the deceased alive on JAN. 17, 1966, and that death occurred at 5:30 P.M. from the causes and on the date stated above.															
22a. SIGNATURE Philip P Felipe												22b. DATE SIGNED JAN 21, 1966			
22c. PHYSICIAN'S NAME (Type) PHILIP P FELIPE, M.D.				22d. ADDRESS 103 Gay St DENTON Md											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF Jan. 22, 1966		23c. NAME OF CEMETERY OR CREMATORIUM St. Paul Cemetery				23d. LOCATION (City, town or county) Near Denton, Maryland							
24e. FUNERAL DIRECTOR F. J. Hampton and Son, Federalsburg, Maryland		ADDRESS Leon Hampton Jr.		25a. REC'D BY REGISTRAR JAN 24 1966				25b. REGISTRAR'S SIGNATURE Charles Judge							
VR A15 (4) 2DM 1/65				DATE											

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